STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIELDS HOUSE	2288 NICHOLAS CT SEYMOUR, IN47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaint IN00091430. Complaint IN00091430 - Substantiated. State residential deficiencies related to the allegations are cited at R-297 and R-241. Survey date: 06/15/11 Facility number: 004376 Provider number: 004376 AIM number: N/A Survey team: Sharon Whiteman RN Census bed type: Residential: 31 Total: 31 Census payor type: Other: 31 Total: 31 Sample: 04 This deficiency also reflects state findings in accordance with 410 IAC 16.2. Quality review completed 6/20/11 by Jennie Bartelt, RN.	R0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to insure 1 of 3 residents reviewed for medications in a sample of 4, received medications as ordered by physician. (Resident #A) Findings include: Review of Resident #A's closed record on 06/15/11 at 11:00 a.m., indicated the following: Resident #A had diagnoses which included, but were not limited to, dementia of Alzheimer's type, depression, and diabetes. A "Post Discharge to Home Instructions" sheet, (not dated) indicated Resident #A was transferred from another facility to Shields House. The instruction sheet listed medications which were sent to Shields House with the resident. The medications included, but were not limited to, (8) Potassium 10 micrograms (mcg) (medication supplement used to	R0241	**Citation #1** **R 241** **410 IAC 16.2-5-4(e) (1)** **Health Services** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident A no longer resides at Shields House. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Wellness Director conducted a review of the Medication Administration Record and the med cart to ensure medication availability. No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The licensed nurses and Qualified Medication Aides were re-educated as to our policy and procedure	07/22/2011

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	prevent Potassium depletion) tablets to be taken twice daily and (3) Lorazepam (antianxiety medication) 1 milligram tablets to be taken 3 times daily as needed. The instruction's sheet also included an order for Furosemide (a diuretic medication) 20 milligrams daily. Interview of QMA #1 on 06/15/11 at 2:20 p.m. indicated the "Post Discharge to Home Instructions" sheet which was sent with Resident #A indicated 8 Potassium tablets were sent with the resident, but only 7 tablets were actually sent with the resident. QMA #1 indicated the resident's admission date to the facility was 05/04/11. Physician's orders, dated May 2011, included an order, dated 05/04/11, which indicated Resident #A was to receive 1 milligram tablet of Lorazepam at bedtime as needed and also 1 milligram of Lorazepam 3 times daily as needed. The order also included another order, dated 05/04/11, which indicated Resident #A was to receive Potassium 10 mcg twice daily. A Medication Administration form for May 2011 indicated Resident #A received 10 mcg tablets of Potassium on the evening of 05/04/11, and two Potassium tablets on 05/06/11 and 05/07/11.		concerning documentation and re-ordering of medications for administration as indicated by the physicians order. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will ensure medications are ordered and available within an appropriate time frame so as to ensure availability for administration. The Wellness Director will perform a random weekly review of the medication cart and resident Medication Administration Record for a period of three months to ensure continued compliance with medication availability. The interdisplinary team will review findings within three months to evaluate the need for the ongoing monitoring plan. Findings suggestive of compliance will result in cessation of monitoring plan. **By what date will the systemic changes be completed?** Compliance Date: 7/22/11	

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A "Nurse's Medication Notes" form for May 2011 indicated there were no Potassium tablets available to give Resident #A on 05/08/11, 05/09/11, 05/10/11, and the morning of 05/11/11. The form indicated the resident had left the facility on the evening of 05/11/11.

Interview of QMA #1 on 05/15/11 at 12:00 p.m., indicated Resident #A had left the facility to return to another facility on the evening of 05/11/11.

The Medication Administration form for May 2011 indicated Resident #A received a 1 milligram (mg) tablet of Lorazepam on 05/05/11 at 7:00 p.m. and 05/07/11 at 7:00 p.m.

Interview of QMA #1 on 06/15/11 at 12:00 p.m., indicated she was certain Resident #A received the third dose of Ativan but probably wasn't documented. QMA #1 indicated she knew the resident was out of Ativan and Potassium and the pharmacy was called, but there was a mix up due to the resident having received her medications at the previous facility and she never received anymore Potassium or Lorazepam after the 05/07/11 administration of the medications. QMA #1 indicated, "I know I gave her the last Lorazepam on Saturday (May 7, 2011)

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	and she (Resident #A) asked for another pill but there were no more Lorazepam tablets available after 05/07/11." QMA #1 indicated she knew the pharmacy was called several times regarding Resident #A not having Potassium and Lorazepam. The facility failed to provide documentation of the pharmacy being called regarding Resident #A needing Lorazepam and Potassium. A "Resident Services Notes" form, dated 05/10/11 at 1:00 p.m., indicated, "Spoke (with) (Resident #A's family) about resident's decision to return to (previous facility)." This state residential tag is related to Complaint IN00091430.			
R0297	(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.			

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	Based on interview and record review, the facility failed to insure 1 of 3 residents reviewed for medications in a sample of 4, had medications available from the pharmacy for administration as prescribed. (Resident #A) Findings include: Review of Resident #A's closed record on 06/15/11 at 11:00 a.m.' indicated the following: Resident #A had diagnoses which included, but were not limited to, dementia of Alzheimer's type, depression, and diabetes. A "Post Discharge to Home Instructions" sheet, (not dated) indicated Resident #A was transferred from another facility to Shields House. The instruction sheet listed medications which were sent to Shields House with the resident. The medications included, but were not limited to, (8) Potassium 10 micrograms (mcg) (medication supplement used to prevent Potassium depletion) tablets to be taken twice daily and (3) Lorazepam (antianxiety medication) 1 milligram tablets to be taken 3 times daily as needed. Interview of QMA #1 on 06/15/11 at 2:20	R0297	**Citation #2 R 297 410 IAC 16.2-5-6 (c) (1) Pharmaceutical Services What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident A no longer resides at Shields House. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Wellness Director conducted a review of the Medication Administration Record and the med cart to ensure medication availability. No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The licensed nurses and Qualified Medication Aides were re-educated as to our policy and procedure concerning documentation and making the necessary provisions to ensure medications for available for administration as indicated by the physicians order. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will ensure medications are ordered and available within	07/22/2011

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	p.m. indicated the "Post Discharge to Home Instructions" sheet which was sent with Resident #A indicated 8 Potassium tablets were sent with the resident, but only 7 tablets were actually sent with the resident. QMA #1 indicated the resident's admission date to the facility was 05/04/11. A physician's order, dated May 2011, included an order, dated 05/04/11, which indicated Resident #A was to receive 1 milligram tablet of Lorazepam at bedtime as needed and also 1 milligram of Lorazepam 3 times daily as needed. The order also included another order, dated 05/04/11, which indicated Resident #A was to receive Potassium 10 mcg twice daily. A Medication Administration form for May 2011 indicated Resident #A received 10 mcg tablets of Potassium on the evening of 05/04/11, and two Potassium tablets on 05/06/11 and 05/07/11. A "Nurse's Medication Notes" form for May 2011 indicated there were no Potassium tablets available to give Resident #A on 05/08/11, 05/09/11, and 05/10/11 and the morning of 05/11/11. The form indicated the resident had left the facility on the evening of 05/11/11.		an appropriate time frame so as to ensure availability for administration. The Wellness Director will perform a random weekly review of the medication cart and resident Medication Administration Record for a period of three months to ensure continued compliance with medication availability. The interdisplinary team will review findings within three months to evaluate the need for the ongoing monitoring plan. Findings suggestive of compliance will result in cessation of monitoring plan. **By what date will the systemic changes be completed?** Compliance Date: 7/22/11	

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	Interview of QMA #1 on 05/15/11 at 12:00 p.m. indicated Resident #A had left the facility to return to another facility on the evening of 05/11/11. The Medication Administration form for May 2011 indicated Resident #A received a 1 milligram (mg) tablet of Lorazepam on 05/05/11 at 7:00 p.m. and 05/07/11 at 7:00 p.m. Interview of QMA #1 on 06/15/11 at 12:00 p.m. indicated she was certain Resident #A received the third dose of Ativan but probably it wasn't documented. QMA #1 indicated she knew the resident was out of Ativan and Potassium and the pharmacy was called, but there was a mix up due to the resident having received her medications at the previous facility and she never received anymore Potassium or Lorazepam after the 05/07/11 administration of the medications. QMA #1 indicated, "I know I gave her the last Lorazepam on Saturday (May 7, 2011) and she (Resident #A) asked for another pill but there were no more Lorazepam tablets available after 05/07/11." QMA #1 indicated she knew the pharmacy was called several times regarding Resident #A not having Potassium and Lorazepam. The facility failed to provide documentation of the pharmacy being			

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	called regarding Resident #A needing Lorazepam and Potassium. A "Resident Services Notes" form, dated 05/10/11 at 1:00 p.m., indicated, "Spoke (with) (Resident #A's family) about resident's decision to return to (previous facility). This state residential tag is related to Complaint IN00091430.			